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ABSTRACT

The American Indian Health Service (AIHS) is a component of the Department of Health, Education, and Welfare's Health Services and Mental Health Administration. AIHS is responsible to 422,000 Indians belonging to more than 250 tribes and 53,000 Indians living in 300 Alaskan villages. The goal of the AIHS is to raise the health of the Indian and Alaskan Native people to the highest possible level and assist them in every way possible to achieve a better quality of life. One of the most significant developments over the years has been the increasing involvement of Indians and Alaskan Natives in all phases of their health program and, most especially, in assumptions of leadership roles. The health programs discussed are: (1) the Indian Health Service (organization); (2) the AIHS Comprehensive Health Program (facilities and services); (3) new directions; (4) special programs, e.g., mental health and otitis media; (5) environmental health; (6) training and education, e.g., community health medics, representatives, aides, and dental assistants; (7) progress since 1955; (8) accomplishments; (9) statistical highlights, such as vital events; (10) health facilities (by states); and (11) administrative offices. (FF)

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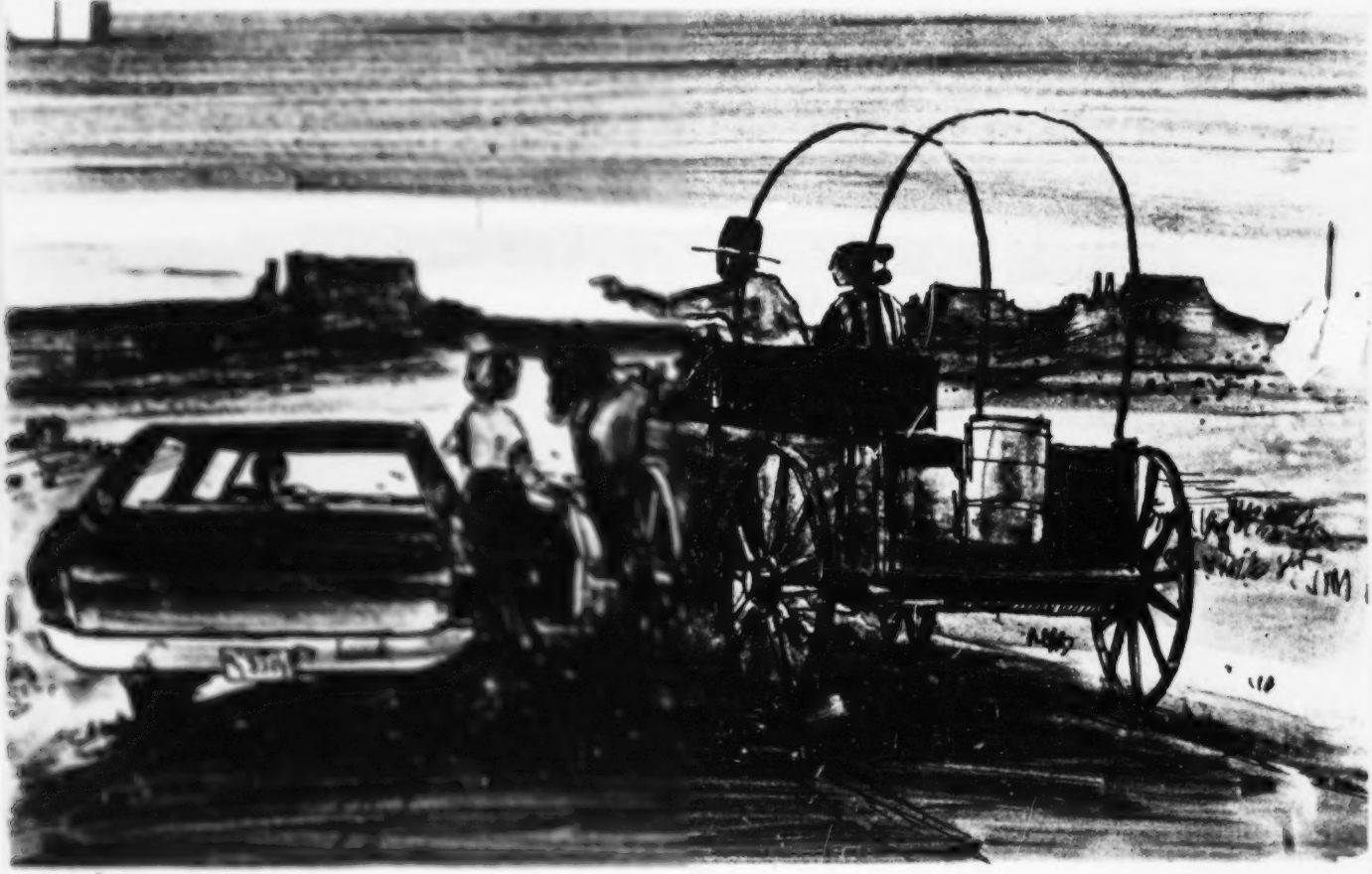
The Indian Health Program of the U.S. Public Health Service



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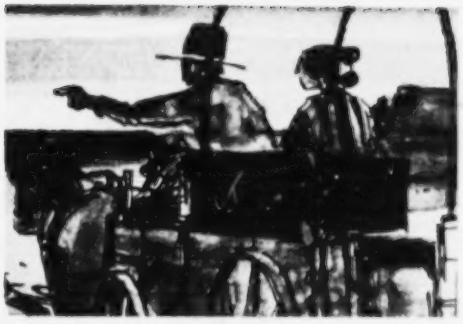

U.S. Public Health Service

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration
Indian Health Service
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Foreword

The Indian Health Service of the Health Services and Mental Health Administration was established July 1, 1955, when the Department of Health, Education, and Welfare assumed the responsibility for the health care of Indians and Alaska Natives from the Department of the Interior.

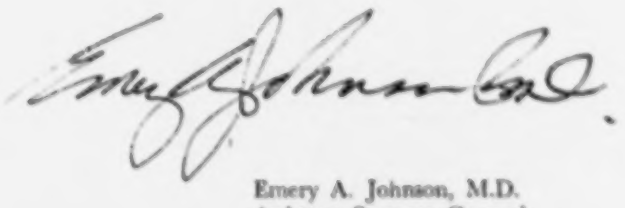
Early efforts of the Indian Health Service concentrated on overcoming the severe health problems of the two populations by improving and expanding health facilities, services and programs. Marked progress has been achieved through the sustained support of the Congress and other private and governmental agencies and the growing participation of Indians and Alaska Natives in health activities.

One of the most significant developments over the years has been the increasing involvement of Indians and Alaska Natives in all phases of their health program and most especially, in assumption of leadership roles. Throughout the Indian Health Service, Indian boards of health are helping to develop policy, determine health needs, establish priorities and to generally participate in the planning, implementation and evaluation of the Indian Health Service program.

Training and employment of Indians and Alaska Natives in the Indian health program has always been of paramount concern. In recent years new opportunities of training and career development have been introduced, and a major emphasis put on increasing Indian and Alaska Native capability to man and manage their own health programs.

In another new development, Federal agencies, including constituencies of the Department of Health, Education, and Welfare, Office of Economic Opportunity, the Department of Labor, and the Department of Housing and Urban Development, are combining resources to meet the needs of Indians.

From this concentration, coupled with the Indians' active self-determination, we look to a significantly improved health status for the first Americans.



Emery A. Johnson, M.D.
Assistant Surgeon General
Director, Indian Health Service

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Cover Art: Clifford Beck

Introduction

According to the 1970 U. S. Census, there are about 827,000 citizens who identify themselves as American Indians and Alaska Natives (Indians, Eskimos, and Aleuts). More than half of these people maintain a unique relationship with the Federal government, enabling them to participate in a number of special Federal programs, including the program of the Indian Health Service. This relationship is rooted in treaties the Government entered into with various Indian tribes and in the numerous laws enacted by the Congress for the benefit of Indians and Alaska Natives.

The majority of American Indians in this group live on Federal Indian Reservations or in rural Indian communities. Alaska Natives live primarily in isolated villages. In general, they have maintained their traditional cultures in language, religion, social organization and values which conflict with the demands of a modern society. Some speak very little or no English, and others speak English as a second language. The average income of Indians and Alaska Natives is among the lowest in the United States, averaging less than $2,000 annually per family. They are among the most impoverished and isolated of any U. S. peoples, and often are deprived of the basic life-serving necessities such as good nutrition and a sanitary environment.

Major transportation and communications problems pose additional barriers to the implementation of health programs. Many patients must travel long distances over primitive roads and difficult terrain to reach hospitals, health centers, or other health facilities. On many reservations public transportation facilities are lacking or inaccessible, and telephones and automobiles are scarce. The very ill, or those needing emergency treatment must be transported by ambulance or airplane, sometimes hundreds of miles. In Alaska, there are virtually no roads in the areas where Natives live and only one railroad in the State. Communications are further hampered by extremes of climate and topography.

A number of special health problems exist in exaggerated proportions that require extraordinary efforts and program expansion. Perhaps the most serious of these is the mental health of a people caught in the conflict of traditional culture values and the demands of a modern society. Otitis media (middle ear disease), which inflicts serious and often permanent damage, has been the leading notifiable disease since 1964. Mild and moderately severe nutritional deficiencies are relatively common. The state of dental health among Indians and Alaska Natives is generally poor. Other areas of concentration are in maternal and child health and environmental health.

A number of health improvements have been realized since 1955. Tuberculosis death rates have declined 75 percent. Infant deaths are down 51 percent, influenza and pneumonia death rates are down 36 percent, and deaths from gastro-intestinal causes are down 53 percent. Tremendous strides have also been made in correcting

environmental deficiencies and providing water and sewage disposal facilities for thousands of families.

The health status of Indians and Alaska Natives, however, still lags 20-25 years behind that of the general population of the United States. To close this gap, programs in public health preventive medicine, as well as curative services are being intensified through the collaborative efforts of the Indian Health Service and the Indians and Alaska Natives themselves. New types of health manpower and delivery systems are being developed with emphasis on improved cross-cultural understanding.

In Alaska remoteness and isolation, major barriers to health care delivery have been diminished with the development of a health aide program. Resident community health aides, trained to provide basic health services, receive medical guidance and supervision via short wave radio from physicians based at distant service unit hospitals. In most instances there is no other resident provider of health care. More than 156 villages are presently being served by 185 Alaska Native Community Health Aides.

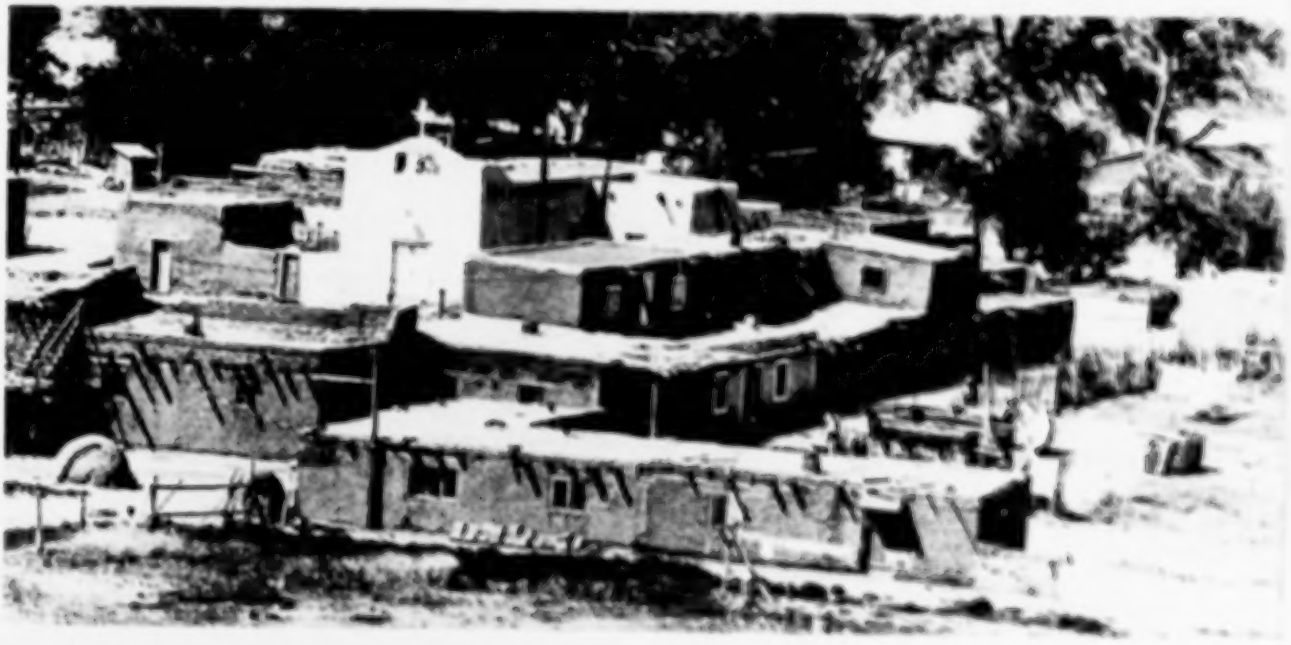
The Indian mental health worker and community health representative programs are other unique concepts for providing health services, which are also designed to cut across cultural barriers.

Indian mental health workers are as-

sisting in family and group therapy in such languages as Lakota or Navajo, as well as in English. They are members of the respective communities with which they work, and have a special understanding of the emotional needs of individuals, families or groups within the community. Their knowledge of cross cultural and language differences, makes the mental health worker particularly effective in dealing with severely disturbed patients who are reluctant to discuss their problems with a non-Indian physician. Additionally, they provide support, encouragement, "emotional first aid," and extensive counseling for the prevention of emotional disorders.

Community health representatives are tribal members, employed by their respective tribal groups, to stimulate community action in the development of a comprehensive health program. They also act as liaison between their respective communities and providers of health care, bringing existing health resources to bear upon the community health problems.

In these and other matters impinging upon their health status, Indians and Alaska Natives are interacting and involving themselves in program activities. Under Indian Health Service leadership and guidance, they are helping to devise more effective ways to utilize all available resources to improve their quality of life.



The Indian Health Service

The Indian Health Service (IHS) is a component of the Department of Health, Education, and Welfare's Health Services and Mental Health Administration (HSMHA), which is working to improve health services and promote better health for all Americans. The responsibility of the Indian Health Service is to 422,000 American Indians belonging to more than 250 tribes and 53,000 Natives living in 300 Alaska villages.

The problems that these citizens encounter in preserving health and obtaining needed health care exceed those of most other Americans. The goal of the Indian Health Service is to raise the health of the Indian and Alaska Native people to the highest possible level and assist them in every way possible to achieve a better quality of life. Interacting with other HSMHA activities in many mutually beneficial ways, and with public and private agencies, the Indian Health Service is developing innovative ways to dispense health services, utilize manpower, stimulate consumer participation and apply resources. In this effort, the Indian Health Service has three major objectives:

- To assist Indian tribes in developing their capacity to man and manage their health programs through activities such as health management training, technical assistance, and human resource development and provide every opportunity for tribes to assume administrative authority through contracts and delegation.
- To act as the Indians' and Alaska Natives' advocate in the health field to generate other interests and resources which can be utilized.
- To deliver the best possible comprehensive health services, including hospital and ambulatory medical care, preventive and rehabilitative services, and to develop or improve community and individual water and sanitation facilities and other environmental factors affecting good health.

ORGANIZATION OF THE SERVICE

Headquarters

The staff of the Indian Health Service headquarters includes health and administrative professionals and clerical staff who support overall operations and provide advice and guidance to field offices. The organizational structure and activities of the staff are geared to serve as a resource for field staff personnel in management, administrative services and various health disciplines.

Field Administration

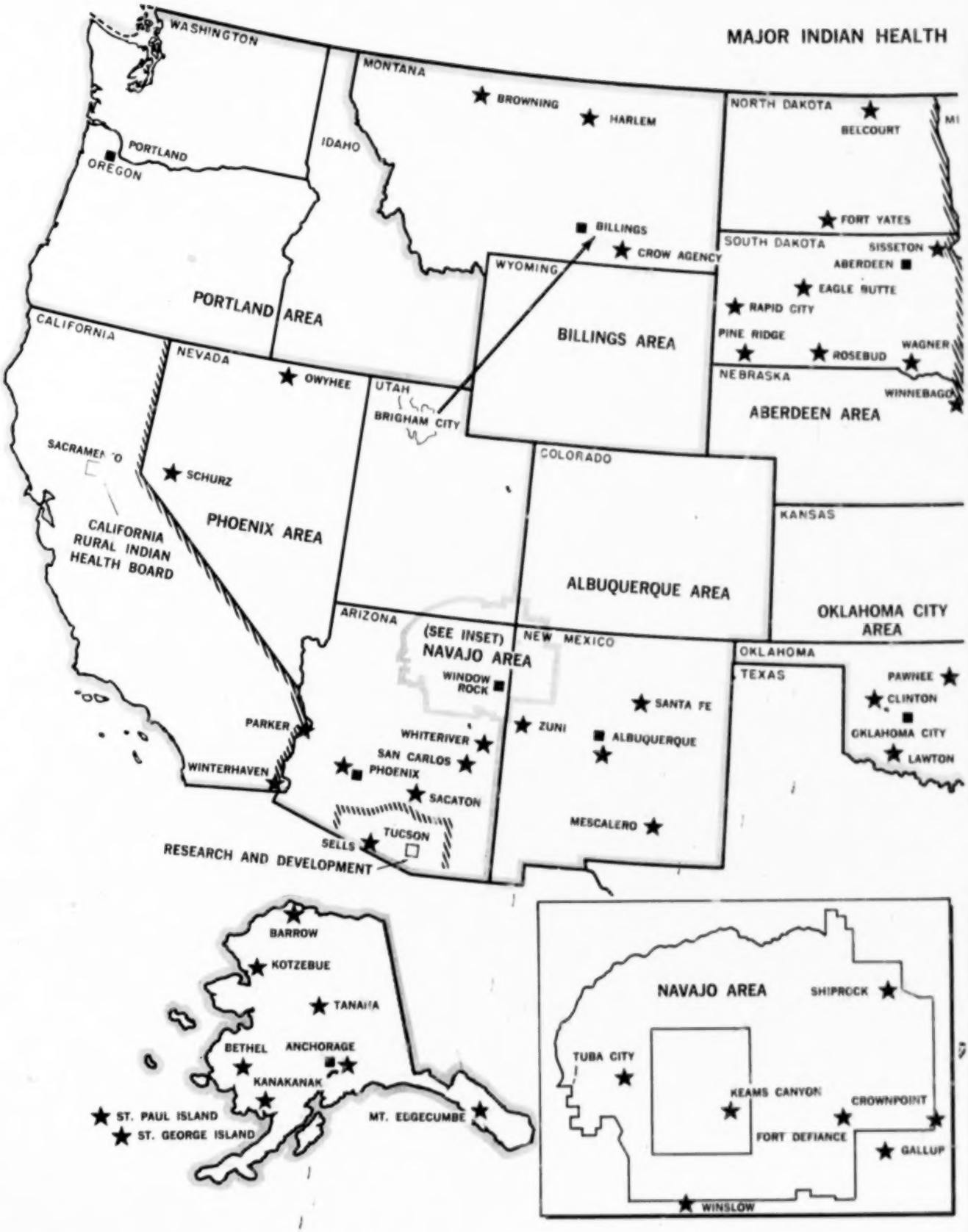
The field service is divided administratively into eight area offices, and four program operations, one of which includes a research and development complex, within the Office of Research and Development in Tucson, Arizona. Each administrative office is responsible for operating the health program within its designated geographical area, utilizing Indian Health Service or contract facilities, to provide comprehensive health care services.

Service Units

Areas are broken down into service units, to facilitate operation of the program. A service unit is the basic health organization in the Indian Health Service program, just as a county or city health department is the basic health organization in a State health department. These are defined areas, usually centered around a single Federal Reservation in the Continental United States, or a population concentration in Alaska. A few units cover a number of small reservations; some large reservations are divided into a number of units. The Navajo Reservation, which covers 24,000 square miles in three States and has a service population of approximately 94,000, is divided into eight service units. Most service units encompass a hospital or health center, staffed by competent health teams.

Research and Training

The Office of Research and Development in Tucson, Arizona combines the Service's Training and Health Program Systems Centers, and the Papago Reservation health program. There, new methods and techniques for health care delivery, reporting systems, and manpower resources and utilization are being developed to provide new insights into the improvement of health care planning, programming, implementation and evaluation.


MAJOR INDIAN HEALTH
WASHINGTON
MONTANA
BROWNING
HARLEM
NORTH DAKOTA
BELCOURT
PORTLAND
OREGON
IDAHO
BILLINGS
CROW AGENCY
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SISSETON
ABERDEEN
EAGLE BUTTE
RAPID CITY
PINE RIDGE
ROSEBUD
WAGNER
WYOMING
PORTLAND AREA
BILLINGS AREA
CALIFORNIA
NEVADA
OWYHEE
UTAH
BRIGHAM CITY
NEBRASKA
WINNEBAGO
ABERDEEN AREA
SACRAMENTO
SCHURZ
COLORADO
KANSAS
CALIFORNIA RURAL INDIAN HEALTH BOARD
PHOENIX AREA
ALBUQUERQUE AREA
OKLAHOMA CITY AREA
ARIZONA
(SEE INSET)
NAVAJO AREA
NEW MEXICO
OKLAHOMA
TEXAS
WINDOW ROCK
SANTA FE
PAWNEE
CLINTON
PARKER
WHITERIVER
ZUNI
ALBUQUERQUE
OKLAHOMA CITY
WINTERHAVEN
SAN CARLOS
PHOENIX
LAWTON
SACATON
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TUCSON
SELLS
RESEARCH AND DEVELOPMENT
BARROW
KOTZEBUE
TANANA
BETHEL
ANCHORAGE
KANAKANAK
ST. PAUL ISLAND
ST. GEORGE ISLAND
MT. EGGECUMBE
NAVAJO AREA
SHIPROCK
TUBA CITY
KEAMS CANYON
CROWNPOINT
FORT DEFIANCE
GALLUP
WINSLOW

FACILITIES IN THE UNITED STATES
NNESOTA
BEMIDJI SUB AREA
RED LAKE
CASS LAKE
WISCONSIN
MICHIGAN
MAINE
NEW YORK
VT
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MASS
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ALABAMA
GEORGIA
S. CAROLINA
MISSISSIPPI
LOUISIANA
PHILADELPHIA
FLORIDA
UNITED SOUTHEASTERN TRIBES PROJECT
LEGEND
National Headquarters
Program Area
P.H.S. Indian Health Area Office Jurisdictions
Hospitals
I.H.S. Area Offices
Program Offices

emphasis on early prenatal care for the mother and continuing care after she and the baby leave the hospital. Health education activities are conducted to teach the mother proper ways to feed, bathe and care for her family within the often limited resources of her home, how to recognize illness, and why it is important to observe good health habits and make regular visits to the clinic.

A nurse midwife program was recently introduced to reach mothers living in isolated areas. The first such program was initiated in Alaska in 1970 to expand and improve the health care of mothers and children, and to demonstrate the role a nurse-midwife can play in reducing maternal and infant deaths. Similar programs have since been instituted in Shiprock, New Mexico, and in the Fort Defiance, Keams Canyon and Chinle Service Units in Arizona. Nurse midwifery services are also being developed in Pine Ridge, South Dakota and Lawton, Oklahoma. In cooperation with the Schools of Nursing, University of Utah and Johns Hopkins University, the program will be expanded to other areas in 1972, including training of additional nurse midwives.

Assistance in family planning as a means of protecting the health of mothers and children, is also an element of comprehensive health care. A family planning program was intensified in 1965. Since that time, through June 30, 1971, 49.8 percent of the 86,000 Indian and Alaska Native women between the ages of 15-44 utilized family planning services in FY 1971. It is expected this figure will rise to 65 percent within the next two years.

The IHS Comprehensive Health Program

The comprehensive health services program is designed to cope with the observed and stated health needs of Indian people and Alaska Natives. It provides a broad scope of primary care and preventive and rehabilitative services, through a system of expanding facilities, manpower, and health programs. Planning and implementation of all phases of the health services program reflect the cooperative efforts of a highly proficient health and administrative professional staff, and consumer representation of the Indian people and Alaska Natives. Tribal health boards, advisory boards, community development activities, Indian training and manpower recruitment programs, local health activities have all helped to assure consumer input. These activities and others provided through tribal contracts provide the resources to enable Indians to man and manage their own program.

In recent years a number of private, State and other Federal governmental health resources have been mobilized to assist Indian Health Service in its mission to improve the health status of Indian people and Alaska Natives. These include programs of other constituencies of the Department of Health, Education, and Welfare, the Department of Housing and Urban Development, the Office of Economic Opportunity, the Bureau of Indian Affairs, the Department of Labor, and the National Council on Indian Opportunity; with a number of States; with individual Indian tribes and intertribal groups; and with private and voluntary Indian interest groups.

FACILITIES AND SERVICES

The program is carried out through a system of 51 hospitals, ranging in size from 6 to 276 beds, 3 of which are 200-bed referral, teaching and research centers, 77 health centers, including 29 school health centers, and more than 300 health stations and satellite field health clinics. Additional medical and dental clinics are held at appointed locations on a regular schedule, daily, weekly, or monthly. Special clinics are held intermittently, as needed. Contracts are also maintained with over 300 private or community hospitals,

more than 18 State and local health departments, and some 500 physicians, dentists and other health specialists to provide hospitalization, and specialized diagnostic and therapeutic services. The contract program is used in locations where there is no Indian Health Service facility, health professional, or alternate resource to provide the required service.

Most service units have a hospital or health center, and a number of satellite clinics, providing inpatient care and outpatient services through preventive and curative clinics. Special services include prenatal, postnatal, well-baby, family planning, diabetes, heart disease, trachoma, tuberculosis and immunization programs. Added services are provided by public health nurses, community health medics (physician assistants), tribally employed community health representatives, nutritionists, health educators, mental health workers, social workers and sanitarians who are engaged in home visits, in follow-ups on discharged tuberculosis patients and newborns and mothers, in health education conferences and in environmental health endeavors.

School health programs are conducted in boarding and day schools operated by the Bureau of Indian Affairs, Department of the Interior, and public schools on Reservations.

Dental services are provided at hospitals, health centers and health stations, and in 18 mobile dental units. In some locations where the Public Health Service has no facilities, care is provided under contract with dentists in private practice. In Alaska, itinerant dental teams travel to remote villages by charter plane taking equipment with them.

Dental care for persons under 17 years of age is given priority, a policy that began to pay dividends in 1968 when the DMF rate (decayed, missing and filled teeth) for Indian Children showed a decline for the first time in 13 years. Expanded resources, increased efficiency and the addition of dental assistants, have contributed to a steadily decreasing DMF rate since then. Reaching all children and providing care for an increasing number of adults are continuing aims.

Environmental health services provided under the direction of Indian Health Service sanitarians, are an integral part of the Indian Health Service total comprehensive health program. In concert with the health staff, the sanitarian works to combat unhealthy environmental conditions and practices, poor and crowded housing, lack of safe water supplies and inadequate waste disposal facilities, all of which contribute to a high rate of infectious diseases.

New Directions

CONSUMER INVOLVEMENT

The increasing involvement of Indian people, especially in leadership roles, has been one of the most significant developments in recent years. A Division of Indian Community Development has been established to make the Indian Health Service more responsive to the health needs of Indian people and their changing role in managing their own health programs.

The National Inter-Tribal Health Board of 12 Indian leaders representing all areas and program offices, Indian health boards, and other committees, are helping to develop policy, determine health needs, establish priorities and allocate resources at each administrative level throughout the Indian Health Service. In addition to health programs, social, economic and other aspects of better health and quality of life are being emphasized. Existing problems are being identified and new ideas, resources and health related programs are being developed to bear upon the problems of health services delivery. The involvement and subsequent contributions of Indian groups have led to changes in health services delivery methods and more effective adaptations of health services in a number of Indian Health Service locations.

NEW COMMUNITY INITIATIVE

Indian and Alaska Native people have taken the initiative to develop and operate a variety of local programs to meet their most critical needs. Many individuals have taken leadership training in health affairs which they are utilizing in their respective reservations and communities. The effectiveness of local action has been demonstrated in direct community health service activities such as programs in nutrition, accident prevention, alcoholism control, suicide prevention, mental health, improved housing and other areas of community action and economic development.

Indian self-determination is rapidly emerging as a working concept. It is uniquely evident in California and the Southeastern United States where Indians are managing their own health affairs.

The California Rural Indian Health Board, under agreement with the Indian Health Service, is arranging the delivery of a variety of health services to approximately 24,000 Indians living in 16 rural California communities. The United Southeastern Tribes Intertribal Council is managing health care for some 9,000 Indians residing in Mississippi, North Carolina, Florida, and Louisiana, through Indian Health Service and contract facilities in those states.

Special Programs

The level of health today among Indians and Alaska Natives is in many respects similar to that of the general population about a generation ago. Physicians encounter a greater variety of clinical conditions in Indian Health Service facilities than in other health programs in the country. Special health needs are met in varied ways with activities keyed to removing the source of the problem.

Mental Health

As the Indian people have been caught more and more in the conflict between their old, traditional culture and the demands of modern American society, mental health problems have increased. The seriousness of mental health problems among Indians and Alaska Natives is demonstrated in age adjusted suicide rates which are two times as high as that of all races, and a homicide rate 3.3 times as high. Indian deaths from alcoholism and related accidents, alcoholic psychosis or cirrhosis with alcoholism are 6.5 times as high as in the general population.

Emotional problems and behavioral disorders are frequent among Indian children in their struggle for identity and achievement of self-sufficiency in a new social set-up. There is increasing need for the mental health component in child guidance and counseling, and for the development of new and effective methods to prevent further trauma to the growing child.

As of this fiscal year, professional mental health teams are working in all Indian Health Service areas, a pilot inpatient mental health program has been introduced, a model dormitory project is being conducted, and training of Indians as mental health workers and technicians has been expanded.

The Indians themselves have undertaken innumerable projects, especially in alcoholism control.

Otitis Media

Otitis media has always been a serious health problem among Indians and Alaska Natives, and in the last decade, has replaced tuberculosis as a major health problem, inflicting serious and often permanent damage.

The extreme prevalence of the disease, with the accompanying demands for prolonged treatment, curative and restorative surgery and rehabilitation created a workload that was impossible to meet out of regular program resources. In 1970 Congress appropriated additional funds especially for an otitis media program, making it possible for Indian Health Service to institute the kind of program necessary to bring this serious problem under control.

Nutrition

Mild and moderately severe nutritional deficiencies are relatively common among Indians and Alaska Natives, especially in infants and preschool children, and women in the childbearing years of 15-44. Malnutrition, a problem in itself, also is a contributing or complicating factor in a wide variety of other health problems and illness. To help improve the nutritional status of Indians and Alaska Natives, the Indian Health Service conducts a family-centered nutrition services program of intensive education, adapting proper principles to the food habits and cultural practices of Indians and Alaska Natives.

Additionally, through the nutrition program of the National Center for Disease Control of the Health Services and Mental Health Administration, four Indian tribes and the Alaska Federation of Natives have grants to conduct demonstration programs to better nutritional health by improving food supplies, training Indian workers, increasing participation in food assistance programs and providing practical information to Indian and Alaska Native people.

Maternal and Child Care

The high rate of illness and death among infants in the first year of life is met with

Environmental Health Program

History

Crowded housing, unsafe water and lack of sanitation facilities have contributed in large part to the high infant mortality, morbidity and excessive rates of infectious diseases among the Indians and Alaska Natives. As early as 1928, the Public Health Service began to provide engineering services to the Bureau of Indian Affairs on the design of sanitary facilities at Indian schools, hospitals and agencies. For the next 20 years, environmental health activities were limited largely to occasional inspections of sanitation facilities on reservations and to an education program in the schools. In the late 1940's and early 1950's, a few contracts for services to Indian groups were developed between the Federal agency responsible for Indian health and State and local health departments.

In 1950, the first sanitary engineer was assigned by the Public Health Service to the Bureau of Indian Affairs to provide consultation in environmental health matters, and to evaluate sanitary conditions on Indian reservations. Three years later a limited professionally staffed sanitation program was begun.

At the time the Indian Health Service was established in 1955, environmental health services were directed primarily toward providing safe, adequate, and convenient water supplies and sanitary waste disposal systems. There was also a need to provide adequate housing.

Legislation

A major breakthrough in improving the physical environment of Indians and Alaska Natives, was made possible when in 1959 Congress passed Public Law 86–121, the Indian Sanitation Facilities Act, enabling construction and maintenance of water supply and waste disposal facilities for Indian homes and communities.

Under this legislation, through fiscal year 1971, a total of 1,131 sanitation projects were undertaken, serving private homes and communities. Over 52,200 Indian and Alaska Native homes were provided with running water and adequate means of waste disposal. Projects included engineering surveys, emergency construction and other special projects, along with instruction in use, care and maintenance of the constructed facilities.

In all of these projects, the Indian people have been active participants, contributing labor, material and funds.

Under cooperative arrangements with the Department of Housing and Urban Development, the Bureau of Indian Affairs, the Office of Economic Opportunity, and various Indian housing authorities, through fiscal year 1970 the Indian Health Service also undertook 361 sanitation construction projects to provide facilities for new or improved housing over and above projects undertaken to serve existing Indian homes and communities. In fiscal year 1971, the Indian Health Service initiated efforts to provide facilities for 7100 units of new or improved housing constructed by other agencies, and for technical assistance for another 900 new housing program homes.

Other Environmental Health Activities

In addition to providing adequate sanitation facilities and training people in their maintenance and use, the Environmental Health Program staff contributes to the ultimate goal of the Indian Health Service through environmental planning, occupational health and safety programs, control of air, water and solid waste pollution, and institutional environmental health programs. Some of the primary activities are:

- Assist tribes in development and adoption of sanitary ordinances and codes.
- Participate in the investigation of communicable disease outbreaks and initiate corrective environmental control measures.
- Evaluate institutional facilities operated by the Bureau of Indian Affairs and the Public Health Service, and make recommendations to the operators of these facilities so that they may attain a healthful environment for the Indians.
- Conduct home and premise evaluations for the purpose of developing and maintaining a current inventory of environmental health deficiencies.
- Continuous evaluation of changing environmental conditions and planning jointly with the Indian tribal officials in the development of a comprehensive environmental health program.

Training and Education Programs

As the Indian health program has expanded and changed to meet the needs of a growing population, education and training programs have also been expanded, and new categories of personnel added. These programs are designed to relieve health manpower shortages, promote career development, and increase participation of Indians and Alaska Natives in their own health programs.

The education and training activities include professional and auxiliary training for Indian Health Service staff; training of Indian people under cooperative efforts with Indian Tribes and training assistance to Government programs in the international field.

More than 55 percent of the health staff are of Indian descent, and in addition to performing their regular duties, they provide valuable interpretive, educational and motivational services.

COORDINATED EFFORTS

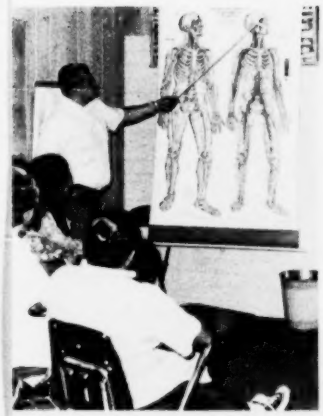
The Indian Health Service has supported a variety of training programs since it came into being. More recently, in its advocacy role, the Indian Health Service has placed greater emphasis on helping Indian tribes plan for greater utilization of health resources available through Federal, State, and local programs to meet their required needs. With added resources, increasing numbers of Indians and Alaska Natives are afforded opportunities to move into professional health and administrative careers enabling them to take on greater responsibilities in their own affairs.

Education and training of Indians and Alaska Natives are being expanded in all areas, to afford maximum utilization of Indian and Alaska Native manpower. The Indian Health Service has concentrated heavily on building professional competencies. In many instances, Indian Health Service has combined resources with those of other agencies within the Health Services and Mental Health Administration, and other Federal agencies, particularly the Bureau of Health Manpower Education of the National Institutes of Health, the Department of Labor, and the Office of Economic Opportunity. As a result, greater support has been extended to Indian people for long-term graduate and undergraduate training in physical medicine, nursing and nursing specialties, pharmacy, environmental health, and health care administration, among others. Work-study arrangements have been developed with many colleges, whereby

Indian students can study for health professions while working in their home communities. School counseling programs have also been established at universities, community colleges, and high schools to identify and place Indian students in health professions' education programs.

PROFESSIONAL EDUCATION AND TRAINING

Education, training and career development opportunities for Indian Health Service professional staff include: specialty training in public health, leading to a master of public health degree, for physicians, dentists, nurses, and other professional staff; physician residency training in pediatrics, surgery, general practice, and preventive medicine; dental internship programs; and, a pharmacy residency program. Training in specialty fields is provided for professional nurses.



Professional staff also has the opportunity at the Indian Health Service Training Center, Tucson, Arizona, to learn principles of epidemiology combined with program planning and managerial practices applicable to the Indian Health Service.

Support is also extended to Indian students in a program of health care administration graduate study. The program, leading to a degree of Master of Public Health, or Master of Science with specialties in hospital administration or community health, accommodates ten students each at the University of California, Berkeley, and the University of Oklahoma.

COSTEP (Commissioned Officers Student Training Extern Program)

The Indian Health Service is a participating agency in the COSTEP program which offers college students in health related studies, an opportunity for career experience in a professional environment. A limited number of students are commissioned as reserve officers in the Public Health Service Commissioned Corps and called to active duty during free periods of the academic year. Reserve officers can serve in any of the Indian Health Service health programs or facilities. Since the inauguration of the program, many health professionals have entered lifetime careers in the Indian Health Service. As more and more Indians move into college and graduate health career programs, they will be given priority in the COSTEP program for assignment in the Indian Health Service.

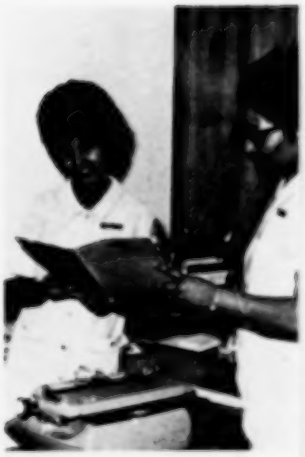
Auxiliary Personnel Training

Allied and auxiliary personnel training has been greatly expanded as a means of supplementing the work of the professional and of increasing involvement of the Indian people.

The role of auxiliary staff has been increased through the provision of training in the categories of community health medic, community health representative, licensed practical nurse, dental assistant, sanitarian aide, medical social work associate, food service supervisor, nutrition aide, laboratory technician, and radiology technician, and on-the-job training is provided in such positions as nursing assistants, food service workers, and medical record clerks.

Community Health Medic (Physician Assistant) Training

The Community Health Medic (CHM) or physician assistant concept was adapted as a means of extending health services to remote locations where there is no full-time physician. The community health medic is trained to provide some primary health services and in addition, to serve as a focal point for a community health program.



Another function for the CHM is to serve directly under a physician in a medical facility, relieving the physician of some of his tasks and permitting him to more efficiently apply his unique skills.

A successful pilot project of community health medic training was completed in 1970 and a formal program initiated in 1971 with 10 in training at the Phoenix Indian Medical Center and 20 at the Gallup Indian Medical Center.

Community Health Representative Training

Community Health Representatives (CHR) are Indian people, selected, employed and supervised by their respective tribes and trained by the Indian Health Service to meet specific tribal needs.

CHR's receive their didactic training at the Indian Health Service Training Center, Tucson, in groups averaging 35 students. The curriculum includes 4 weeks of classroom work and 6 weeks of field experience under the supervision of professional medical personnel. CHR's learn the concepts of health and disease, basic health skills, home nursing, first aid, nutrition, health education and environmental health. Principles of communication, group organization, and planning and conducting meetings are also taught. Through Fiscal Year 1971, 410 community health representatives, from over 100 tribal groups have been placed under contract with the Indian Health Service. This program will improve communications between the Indian community and providers of health services, and increase basic health care and instruction in Indian homes and communities.

Community Health Aide Training in Alaska

The community health aide training program was developed to provide a health resource on the scene for people in remote, inaccessible villages in Alaska. Training emphasizes skills which enable the aide to deliver a wide range of medical services under professional supervision received via short wave radio or telephone from Alaska Native hospitals. Aides are selected by the tribe or village, and are often the only health-trained person in permanent residence. They also serve to stimulate community health activities, promote local participation in health programs, locate new health resources and devise innovative ways of using them. More than 185 Alaska Native community health aides, representing about 156 Alaska villages have thus far been trained. The program will eventually provide aides in 250 native villages.

Training in Environmental Health Services

To bridge the gap of acceptance of modern sanitary practice by Indian groups, the concept of the Indian sanitarian aide has been developed. Indians are given intensive training in basic elements of

communicable disease transmission, sanitary practices and health education techniques, and are then assigned to work on reservations with the Indian people. Basic and advanced courses are given each year with the latter adjusted to provide staff competencies needed for program operations.

Short-term training is provided in radiological health (detection and correction of hazards in institutional and hospital equipment such as X-ray), program management, epidemiology, well drilling and other specialties.

Health Record Technician

Career opportunities for young Indian men and women in the health record field are available through an accredited two-year program of academic study at any approved junior college, and on-the-job training. Sponsored in conjunction with the Bureau of Indian Affairs and the college, this open-end training which can lead to a baccalaureate degree, was developed to help meet the shortage of health record librarians in Indian health hospitals.

Practical Nurse Training

More than 1,100 students have graduated from the Indian Health Service School of Practical Nursing in Albuquerque, New Mexico. Some 50 to 80 young girls of Indian descent, receive training each year as practical nurses.

The courses provide one year of classroom study and practice as well as clinical experience under supervision in a Public Health Service Indian hospital. The school is accredited by the National Association of Practical Nurse Education and the graduates take State board examinations to qualify as licensed practical nurses. Advanced programs are also available to practical nurses at the Public Health Service Indian Hospital in Rapid City, South Dakota, and at the Public Health Service field health training center at Shiprock, New Mexico. A limited number of qualified licensed practical nurses now also have an opportunity to enroll in pro-

fessional schools of nursing through a special appropriation for this purpose.

Laboratory and Radiologic Training

As part of a laboratory improvement program the Indian Health Service conducts a one year school to train certified laboratory assistants and a two year school of radiologic technology for Indian students at the Public Health Service Indian Hospital in Gallup, New Mexico. The program further insures the availability of competent laboratory assistants and radiological technicians to staff Indian Health Service hospital laboratories.

Dental Assistants Training

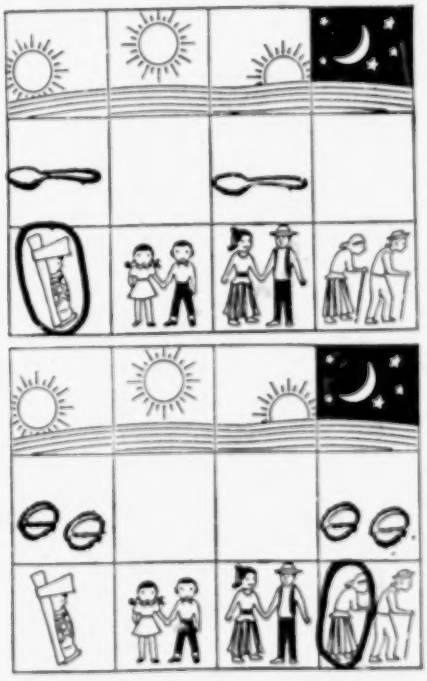
Three dental assistant training programs in Indian schools in Albuquerque, New Mexico; Lawrence, Kansas; and Mt. Edgecumbe, Alaska, are operated to train Indians and Alaska Natives who are high school graduates. The programs are one year in length and students are trained in chair-side assisting, preventive services and efficient dental practice management and expanded duties. The training programs at Albuquerque and Lawrence are certified by the Council on Education of the American Dental Association. Graduating dental assistants are eligible for certification after taking the required examination.

Approximately 44 dental assistants are graduated from these three programs each year and most of them are subsequently employed at various Indian health dental facilities. These Indian and Alaska Native assistants make a significant contribution to the Service's dental program. It is estimated that well-trained dental assistants increase the dental services by more than 30 percent.

Mental Health Workers

The mental health worker is a necessary member of the mental health team. Mental health services are provided as an integral part of the comprehensive health program.

Mental health workers are Indians who have a thorough knowledge of the physical, psychological and social makeup of Indian culture. They understand Indian attitudes toward health and illness, and are highly sensitive to the needs of the community in which they work. As such, the mental health worker is instrumental



Picture labels are used to guide patients in the use of prescription drugs dispensed to Navajo Reservation Indians who do not understand English. In the privacy of the IHS pharmacist's office, patients are also counseled to insure they understand instructions.

in facilitating communication between the Indian and non-Indian medical community, and acceptance of mental health activities by the Indian community.

More than 50 mental health workers have been trained to assist psychiatrists, psychologists, psychiatric social workers and other mental health professionals in providing therapy services to Indian communities and in schools, hospitals and health centers. A like number are currently being trained.

Mental health worker training consists of study, and closely supervised tutelage by mental health professionals, in an environment familiar to the mental health worker, usually his own community. As he gains experience and knowledge in professional methods, the mental health worker is afforded greater independent responsibility to work as a member of the total health team.

Social Work Associate Training

A two-year program consisting of on-the-job training, as well as formal education, is conducted to prepare Indians and Alaska Natives as social work associates with the Indian Health Service. Social work associates augment the professional medical and mental health social staff, serving patients, families, and communities. In addition to providing applied and practical services, the worker assists patients in obtaining all available medical services. In remote and inaccessible areas, the associate social worker often works without direct supervision.

Food Service and Nutrition Training

The Indian Health service also conducts a 13-month training course for food service supervisors and a 12-month course for nutrition technicians to help improve the quality of nutrition and dietetic services, and to offer Indian people opportunities for occupational development and career promotion.

Training for Tribal Advisory Boards

The Indian Health Service has long sponsored and encouraged the conduct of leadership training for Indians serving on local or national health boards and in other tribal capacities. Such training was given increased emphasis as more and more Indians became actively involved in the

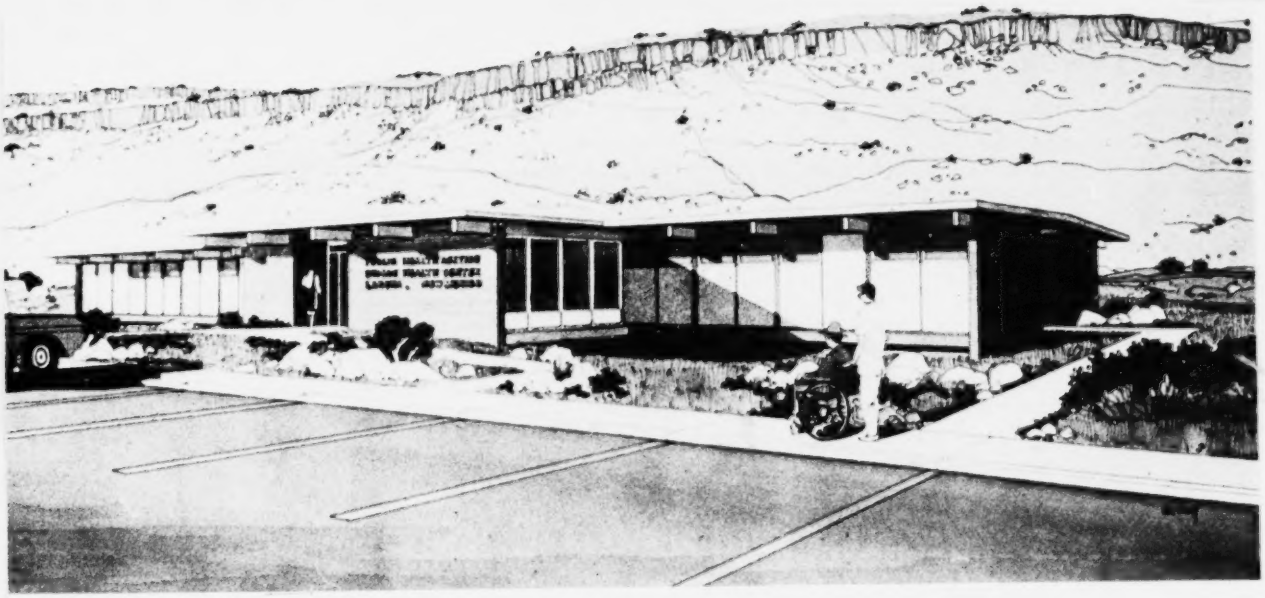
management of their health affairs. A series of formal management institutes in up-to-date management principles was conducted in 1968 and 1969, under the sponsorship of the Indian Health Service and Arrow, Inc. These institutes were attended by more than 80 leaders from Indian communities in various parts of the country. More recently, the joint resources of the Indian Health Service, the Department of Labor, and the U. S. Civil Service Commission have made it possible to launch an expanded program in leadership training. Training programs are conducted at local, area, and national levels and include management and supervision, personnel development, financial and budget management, computer services, among others, designed to meet stated tribal and community needs.

Consultive and International Training Assistance

Indian Health Service experiences, especially those involving delivery of health care in isolated areas and cross-cultural settings, and consumer participation, have provided important consultive and training resources for both domestic and foreign organizations. Conversely, these activities enable Indian Health Service staff to add to their experience and knowledge through contact with foreign investigators and people from countries where health problems and environmental situations are similar to those of many Indians. Each year, for periods extending up to six months, a number of physicians, nurses and students in the medical professions are provided training and observation opportunities at Indian Health Service facilities and field stations throughout the U. S.

The Indian Health Service entered into a Participating Agency Service Agreement (PASA) with the Agency for International Development (AID) to assist the Liberian government in developing and operating the John F. Kennedy Memorial Medical Center in Monrovia, Liberia, and to act as consultant and advisor to the Liberian National Public Health Service. The medical center consists of a modern 250-bed teaching hospital, with outpatient and research facilities (opened in 1971), a 150-bed maternity hospital, and the Tubman National Institute for Medical Arts, which provides courses in nursing, sanitation, medical assistant training and midwifery. The Service also acts as the coordinating agency, and assists in selection of Liberian candidates for advanced medical and paramedical training in the United States, many of whom receive at least a part of their training at an Indian Health Service facility.

Indian Health Service staff are participating with other countries in research of health problems similar or relevant to those existing in Indian communities in the United States, and working for the subsequent alleviation of those problems. Infant health, hearing defects, diabetes, and trachoma, have been investigated under this program. Other health problems also prevalent in the Indian community, which are presently under consideration, are mental health, otitis media, communication, and consumer participation. This program is made possible by P.L. 83–480 which provides support for internationally coordinated medical and scientific research against diseases.



Progress Since 1955

In 1955, when the Department of Health, Education, and Welfare assumed responsibility for the health care of Indians and Alaska Natives, both medical facilities and personnel were inadequate to meet the existing health needs.

The initial program priorities were to assemble a competent health staff; establish adequate facilities where services could be provided; institute extensive curative treatment for the many Indians who were seriously ill; and develop and initiate a full-scale preventive program which would reduce the excessive amounts of illnesses and early deaths, especially from preventable diseases, and generally build a stronger, healthier people.

These were not improvements or expansions that could be achieved immediately. Many were set as basic program objectives and are still applicable. Much progress has been made however, in meeting these objectives, as a result of strong continued and increasing support of the Congress, the assistance of numerous private and Governmental agencies and the active participation of Indian and Alaska Native people. Both staff and responsibilities have expanded.

The staff has increased from a small health staff centered around a nucleus of physicians and nurses, to more than 7,000. The number of physicians rose from 125 to 400, dentists from 40 to 170, and nurses from 780 to more than 1,000. Many other categories of health personnel have been added through the years, including field health physicians, pharmacists, medical record librarians, public health nurses, community health medics and aides, practical nurses, dental assistants, maternal and child health specialists, medical social workers, nutritionists, dietitians, health education specialists, environmental sanitarians, and auxiliaries in a number of categories.

Since 1955, 13 hospitals, 15 health centers and 54 field health stations have been built, and major alterations have been made at 11 other facilities. Through Public Law 85–151, 147 beds to serve Indians and Alaska Natives have been added in 18 community hospitals which were constructed with Hill-Burton assistance.

Additionally, the capabilities of the Indian Health staff have been expanded through numerous health education and training activities, designed to increase efficiency, augment manpower resources and promote career development.

Dramatic increases in the use of services have occurred since 1955. Virtually all Indian births occur in hospitals. Annual admissions to Indian and contract hospitals have nearly doubled; outpatient visits made to hospitals, health centers and field clinics have more than quadrupled; and the number of dental services provided has more than quadrupled.

Accomplishments

Health levels among the two indigenous populations have substantially improved. From 1955 to 1968 infant death rates have declined from 62.5 to 30.9 per 1,000 live births; tuberculosis death rates are down 75 percent; gastroenteric death rates are down 53 percent, and death rates from influenza and pneumonia are down 36 percent.

Tuberculosis, once the number one scourge of Indians and Alaska Natives has been dramatically contained. In 1956 for example, the Indian Health Service had 3,606 tuberculosis admissions to PHS Indian and contract hospitals. In fiscal year 1969, there were only 830 tuberculosis admissions. This represents a decline of 77 percent in tuberculosis hospital admissions.

New active case rates of tuberculosis among Indians and Alaska Natives also have been dramatically reduced. They are down 44 percent since 1962.

In addition, life expectancy for Indians and Alaska Natives is 64 years as compared to 70 for the general population. In 1950 the Indian life expectancy was 60 years and that of the general population, 68 years—the gap is narrowing.

There are other manifestations of better general health reflected in a leveling off of hospitalizations and a continuing large increase in clinic visits, signifying less severe illnesses and fewer people requiring prolonged hospital care. These changes indicate a stabilization of therapeutic health activities and the growing acceptance of health maintenance measures by Indians and Alaska Natives.

Historical Background of the Indian Health Program

THE BEGINNING

Health services for American Indians began in the early 1800's when Army physicians took steps to curb smallpox and other contagious diseases of Indian Tribes living in the vicinity of military posts. Treaties committing the Federal Government to provide health services were introduced in 1832, when a group of Winnebagos was promised physician care as partial payment for rights and property ceded to the Government. Of almost 400 treaties negotiated with Indian Tribes from 1778 to 1871, about two dozen provided for some kind of medical service. Although most treaties imposed time limits of 5 to 20 years for provision of care, the Federal Government adopted a policy of continuing services after the original benefit period expired.

EARLY GROWTH

Transfer of the Bureau of Indian Affairs from the War Department to the Department of the Interior in 1849, stimulated the extension of physicians' services to Indians by emphasizing non-military aspects of Indian administration and by developing a corps of civilian field employees. Within 25 years about half of the Indian agencies had a physician, and by 1900 the Indian Medical Service employed 83 physicians, including those giving part-time services.

Nurses were added to the staff in the 1890's and grew from 8 in 1895 to 25 in 1900 with practically all of them assigned to Indian boarding schools. Beginning in 1891, field matrons were employed to teach sanitation and hygiene, provide emergency nursing service and prescribe medicine for minor illnesses, activities which were later taken over by public health nurses.

Indian Bureau policy by the late 1880's clearly directed physicians to promote preventive activities, but efforts were limited until well after the turn of the century due to pressure of curative work.

The first Federal hospital built for Indians was constructed in the 1880's in Oklahoma and a concentrated movement was underway before 1900 to establish hospitals and infirmaries on every reservation and at every boarding school. The reasons for construction were the isolation

in which Indians lived, the lack of nearby facilities, and home conditions which made prescribing a course of treatment outside a hospital often useless and sometimes dangerous to the patient.

TWENTIETH CENTURY MILESTONES

Professional medical supervision of Indian health activities was begun in 1908 with establishment of the position of chief medical supervisor, and was strengthened in the 1920's by creation of the Health Division and appointment of district medical directors. The first appropriation earmarked specifically for general health services to Indians was made in 1911. In 1926, medical officers of the Public Health Service Commissioned Corps were detailed to certain positions in the program, and in 1955, when the responsibility for the program was transferred by Congress from the Department of the Interior, more than 30 physicians, about a dozen public health nurses, several dentists, sanitary engineers and pharmacists were on detail to the Indian Bureau from the Public Health Service.

Individual disease control programs, such as tuberculosis, were begun early in 1900's and health education activities to support these programs were introduced in 1910.

Dental services were organized in 1913 with assignment of five itinerant dentists to visit reservations and schools.

Pharmacy services were organized in 1933 with PHS pharmacy officers assigned to headquarters, area offices, and hospitals to develop and institute dispensing, packaging, and distribution policies and practices.

Until the late 1920's sanitation services did not extend beyond occasional "clean-up" campaigns and physicians' inspections of homes, schools, and Indian agencies. In 1928, sanitary engineers of the Public Health Service began assistance to the Bureau of Indian Affairs in surveying water and sanitation systems and investigating other basic sanitary problems, usually restricted to Bureau installations. An expanded program to improve sanitation in individual homes began in 1950, and in 1959 legislation was passed authorizing the construction of sanitation facilities for Indian homes and communities.

Statistical Highlights

SERVICE POPULATION

The estimated number of Indians and Alaska Natives eligible for Federal health services is about 475,000. Most of them live on reservations in 23 States and in isolated villages in Alaska. Following are estimated numbers by Indian Health Service administrative areas:

Aberdeen, S. Dak. (S. DAK., N. DAK., NEBR.)	46,000
Anchorage, Alaska	53,000
Albuquerque, N. Mex. (PARTS OF N. MEX. AND COLO.)	34,000
Bemidji, Minnesota (IOWA, MICH., MINN., WISC.)	21,000
Billings, Mont. (MONT., WYO.)	27,000
Oklahoma City, Okla. (OKLA., KANS.)	104,000
Phoenix, Ariz. (NEV., UTAH, PARTS OF ARIZ. AND CAL.)	51,000
Portland, Ore. (IDAHO, ORE., WASH.)	26,000
Navajo, Window Rock, Ariz. (PARTS OF ARIZ., N. MEX., UTAH)	94,000
Tucson Program Office (PART OF ARIZ.)	10,000
United Southeastern Tribes Program (FLORIDA, LA., MISS., N.C.)	9,000

CHARACTERISTICS OF THE POPULATION

Indians and Alaska Natives differ markedly in their demographic, social and economic characteristics from the general population. They are a younger population on the average, with a median age of about 17 years, compared with a median age of about 28 for the U.S. population as a whole. In terms of educational attainment, data from the National Census of 1960[1], showed the median number of school years completed by Indians 14 years and over to be approximately eight years, compared to 10.6 for the population as

[1] Nonwhite Report Census Highlights, P.XI.

a whole. The discrepancy would be greater were comparisons made on the basis of persons 25 years and older; however, comparable data for Indians are not available.

From an economic standpoint, Indians also compare unfavorably with the total population. Most of them reside on land marginal in productivity and in areas of limited employment opportunities. Data from the 1960 Census, though not representing complete coverage indicated a median family income of $1,900. Data for subsequent years, collected by the Bureau of Indian Affairs substantiated this figure.

Housing conditions bear similar unfavorable comparisons. Data collected by the Indian Health Service over a period of years on a number of reservations indicate that more than half of the American Indians and Alaska Natives live in one or two-room dwellings, with an average occupancy of 5.4 persons.[2]

VITAL EVENTS

Birth Rates (live births per 1,000 population) 1968 (calendar year)

Indian and Alaska Native	32.7
U. S. All Races	17.5

Indian and Alaska Native birth rates, after steadily increasing from 1954 through 1964, have declined since 1965. The birth rate in 1954 was 37.3 per 1,000 population, reaching its peak in 1964 with a rate of 43.3. In 1968 the Indian and Alaska Native birth rate was almost twice that for All Races.

Infant Death Rates per 1,000 Live Births, 1968 (calendar year)

Indian and Alaska Native	30.9
U. S. All Races	21.8

The Indian and Alaska Native infant death rate has declined about 51 percent since 1955, but is still about 1.4 times as high as that of the general population.

Neonatal Death Rate Per 1,000 Live Births, 1968 (calendar year)

Indian and Alaska Native	14.4
U. S. All Races	16.1

The death rate among Indian and Alaska Native infants under 28 days of age (the neonatal rate) has declined about 37 percent since 1955 and is now about the same as that for the general population. Major causes of neonatal deaths include immaturity, postnatal asphyxia and atelectasis, congenital malformations, birth injuries, and pneumonia of newborn.

Postneonatal Death Rates Per 1,000 Live Births, 1968 (calendar year)

Indian and Alaska Native	16.5
U. S. All Races	5.7

The death rate among Indian and Alaska Native infants 28 days through 11 months of age since 1955 has been reduced by more than 59 percent, but is still almost three times higher than in the general population. The chief causes of postneonatal deaths are respiratory, digestive, infective and parasitic diseases, accidents, and congenital malformations.

Leading Causes of Death, 1968 (calendar year)

Leading causes of death among Indians and Alaska Natives were accidents, diseases of the heart, malignant neoplasms, influenza, pneumonia, and cirrhosis of the liver. These six causes of death which accounted for nearly 55 percent of the total Indian and Alaska Native deaths in 1968, have changed little in order of importance over the years. Accidents continue as the leading cause with a crude death rate of almost four times that of the general population—198.4 deaths per 100,000 to 53.1 for U.S. All Races.

HEALTH FACILITIES AND HEALTH SERVICES

PHS Indian Hospitals and Contract Hospitals

The Indian Health Service operates 51 general hospitals, most of which are located in Arizona, New Mexico, Oklahoma, South Dakota, and Alaska. A tuberculosis unit is maintained as an integral part of the general hospitals located in Albuquerque, New Mexico, Rapid City, South Dakota, and Anchorage, Alaska.

The total available beds in IHS hospitals

[2] From reprint "Indian Poverty and Indian Health," P.XXVIII.

number 2,967 (excluding bassinets for newborn).

In addition to the PHS Indian hospitals, about 1,000 beds are available through contractual arrangements with several hundred community general hospitals and State and local government tuberculosis and mental hospitals.

Illnesses Requiring Hospital Services

Illnesses and diseases for which Indian and Alaska Natives are hospitalized provide one of the important indices for identifying health problems.

Leading causes of hospitalization in fiscal year 1968 were:

- Deliveries and complications of pregnancy
- Injuries
- Respiratory system diseases
- Diseases of the digestive system

Pediatric patients accounted for almost a third (31 percent) of the discharges from Public Health Service and contract general hospitals, a much higher percentage than for the general population.

Hospital Inpatient Services

Admissions to all hospitals, including those under contract, increased almost 64 percent between fiscal years 1956 and 1971. Almost 99 percent of all admissions were general medical patients and about 26 percent of the admissions were to contract hospitals.

INPATIENT SERVICES
PHS INDIAN HOSPITALS AND CONTRACT HOSPITALS
Fiscal Years 1956 and 1971

Admissions by Type of Patient	1971	1956
Total Admissions	94,945	57,975
General Medical	94,000	54,289
PHS Indian Hospitals	70,275	43,773
Contract Hospitals	23,725	10,516
Tuberculosis and Neuropsychiatric	945	3,686
TB PHS Indian Hospitals	454	2,445
TB Contract Hospitals	134	1,161
Neuropsychiatric Contract Hospitals	357	80

Outpatient Facilities and Outpatient Services

Each Indian hospital provides outpatient services, and the Service also operates 77 health centers including 29 at Bureau of Indian Affairs (Interior) boarding schools. Each center has at least one full-time health staff member: a physician, a dentist or a clinic nurse, assisted by other auxiliary health staff. The Service also provides itinerant health services at more than 300 health clinics.

Medical and dental services also are provided through contractual arrangements in hundreds of physicians' and dentists' offices, private and community clinics and in other non-Federal settings.

Medical Services 1971 (fiscal year)

Visits to PHS Indian hospital clinics	1,202,030
Visits to Indian Health Centers, satellite field clinics, schools and other units	993,210
Visits to contract physicians	174,500

Dental Services 1971 (fiscal year)

	IHS Dental Clinicians	Contract Dentists
Patients Examined	146,901	21,808
Corrective and Preventive Services	684,612	91,556

Estimated population treated rose to almost 36 percent in 1971. Corrective and preventive services provided in 1971 (776,168) increased 13.9 percent over 1968.

Public Health Contracts with Health Departments

The Indian Health Service contracts with 30 State and county health departments for public health services, that include public health nursing, sanitation, tuberculosis and other communicable disease control activities.

Budget—July 1, 1971–June 30, 1972

Indian Health Services	$153,027,000
Indian Health Facilities	1,492,000
Sanitation Facilities	28,950,000
Total	$183,469,000

Hospitals—Indian Health Service

Location	No. of Beds	Outpatient Visits, 1971
Alaska		
Anchorage*	*381	63,346
Barrow	14	11,614
Bethel	43	24,026
Kanakanak	31	4,668
Kotzebue	40	17,436
Mt. Edgecumbe	150	9,815
St. George	6	1,511
St. Paul	7	2,359
Tanana	26	3,919
Arizona		
Ft. Defiance	109	69,424
Keams Canyon	38	28,757
Parker	20	12,523
Phoenix	200	60,559
Sacaton	30	26,444
San Carlos	36	31,743
Sells	50	16,839
Tuba City	75	39,943
Whiteriver	32	33,653
Winslow	33	22,824
California		
Winterhaven	19	10,647
Minnesota		
Cass Lake	21	17,263
Red Lake	22	19,476
Mississippi		
Philadelphia	21	12,147
Montana		
Browning	34	31,036
Crow Agency	34	20,697
Harlem	22	11,071
Nebraska		
Winnebago	51	15,735
Nevada		
Owyhee	19	8,370
Schurz	25	9,469
New Mexico		
Albuquerque*	97	3,887
Crownpoint	50	29,394
Gallup	207	74,786
Mescalero	15	12,641
Santa Fe	37	14,475
Shiprock	75	61,354
Zuni	33	15,663
North Carolina		
Cherokee	21	27,498
North Dakota		
Belcourt	50	34,801
Ft. Yates	30	13,853
Oklahoma		
Claremore	66	36,627
Clinton	26	10,382
Lawton	80	39,669
Pawnee	28	15,251
Tahlequah	57	42,461
Talihina	228	20,192
South Dakota		
Eagle Butte	31	19,053
Pine Ridge	56	38,408
Rapid City*	86	**
Rosebud	49	27,261
Sisseton	32	17,472
Wagner	24	9,515
Totals:		
No. of Hospitals		51
No. of Beds		2,967
No. of Outpatient Visits, 1971		1,202,030

*Includes TB beds.
**Reported by Rapid City health center.
Note: Hill-Harris standards used in determining bed capacity.

Health Centers—Indian Health Service

Location	Visits in 1971
Alaska	
Fairbanks	7,861
Ft. Yukon	3,739
Juneau	14,427
Ketchikan	12,126
Metlakatla	7,120
Mt. Edgecumbe*	1,694
Nome**	
Wrangell*	691
Arizona	
Chinle (2)	45,866
Dilkon	***
Holbrook*	556
Kaibeto*	2,546
Kayenta	17,766
Leupp*	***
Lower Greasewood*	5,179
Many Farms*	856
Peach Springs[1]	5,562
Phoenix*	1,766
Santa Rosa	4,752
Shonto*	6,452
Toyei	***
Tuba City*	***
Tucson	8,911
California	
Riverside*	1,270
Colorado	
Ignacio	4,231
Idaho	
Fort Hall	14,552
Kansas	
Holton	4,719
Lawrence*	3,091
Minnesota	
White Earth	7,760
Montana	
Lame Deer	17,377
Poplar	17,340
Rocky Boy's	11,244
St. Ignatius**	
Nevada	
Stewart*	1,798
New Mexico	
Albuquerque*	2,523
Crownpoint*	***
Dulce	13,778
Ft. Wingate (2)	6,355
Laguna	14,046
Shiprock*	31
Southwestern Polytechnical*	***
Taos	8,269
Teec Nos Pos*	43
Tohatchi	6,933
North Dakota	
Ft. Totten	10,174
Minni-Tohe (Four Bears)	
Wahpeton*	819
Oklahoma	
Anadarko	8,362
Chilocco*	1,097
Concho*	971
Hartshorne*	255
Idabel	2,272
Jay	[1]
Okemah	4,241
Shawnee	21,911
Sequoyah*	838
Tishomingo	6,209
Watonga	4,201
Wyandotte[1] (Seneca)	416
Oregon	
Chemawa*	5,924
Warm Springs	12,015
South Dakota	
Flandreau*	1,491
McLaughlin	6,677
Pierre*	497
Rapid City	20,471
Wanblee	6,258
Utah	
Ft. Duchesne	9,198
Brigham City	11,990
Washington	
Colville	7,670
Lummi	***
Neah Bay	6,814
Northern Idaho**	
Taholah	6,869
Yakima (Toppenish)	21,680
Wyoming	
Ft. Washakie	19,881
Totals:	
No. of Visits in 1971	482,431
No. of Health Centers	77

*School health centers. The number reflects patients seen by physicians; does not include those seen by dentists or nurses.
**Medical Services provided by contract medical care facilities.
***Designated health center July 1, 1971.
[1] Services provided by Health Center Satellite to Claremore Hospital.

IHS Administrative Offices

NATIONAL

Indian Health Service
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

AREAS

ABERDEEN, South Dakota 57401
405 Citizens Building
BEMIDJI Sub Area, Minnesota 56601
203 Federal Bldg.

ALBUQUERQUE, New Mexico 87101
Room 4005 Federal Office Building and
U. S. Courthouse, 500 Gold Ave., S. W.

ANCHORAGE, Alaska 99501
P. O. Box 7–741

BILLINGS, Montana 59103
3 7th Street West, or P. O. Box 2143

OKLAHOMA City, Oklahoma 73102
388 Old Post Office & Court House Building

PHOENIX, Arizona 85014
801 East Indian School Road

PORTLAND, Oregon 97205
921 Southwest Washington St.

NAVAJO, Window Rock, Ariz. 86515
P. O. Box G

Office of Research & Development
Indian Health Service
P. O. Box 11340
Tucson, Arizona 85706

IHS Training Center
P. O. Box 17510
Tucson, Arizona 85710

United Southeastern Tribes Program
1970 Main St.
Sarasota, Florida 33577

California Rural Indian Health Board
2800 Cottage Way
Sacramento, California 95825

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